

**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



**Rick Scott**  
Governor

**Celeste Philip, MD, MPH**  
Surgeon General and Secretary

**Vision:** To be the **Healthiest State** in the Nation

### DESIGNATION OF HEALTH CARE SURROGATE FOR MINOR

I/We, \_\_\_\_\_, the [ ] natural guardian(s) as defined in s. 744.301(1), Florida

Statutes; [ ] legal custodian(s); [ ] legal guardian(s) [check one] of the following minor(s): \_\_\_\_\_;

\_\_\_\_\_ ; \_\_\_\_\_

pursuant to s. 765.2035, Florida Statutes, designate the following person to act as my/our surrogate for health care decisions for such minor(s) in the event that I/we am/are not able or reasonably available to provide consent for medical treatment and surgical and diagnostic procedures:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip code \_\_\_\_\_ Phone: \_\_\_\_\_

If my/our designated health care surrogate for a minor is not willing, able, or reasonably available to perform his or her duties, I/we designate the following person as my/our alternate health care surrogate for a minor:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip code \_\_\_\_\_ Phone: \_\_\_\_\_

I/We authorize and request all physicians, hospitals, or other providers of medical services to follow the instructions of my/our surrogate or alternate surrogate, as the case may be, at any time and under any circumstances whatsoever, with regard to medical treatment and surgical and diagnostic procedures for a minor, provided the medical care and treatment of any minor is on the advice of a licensed physician.

I/We fully understand that this designation will permit my/our designee to make health care decisions for a minor and to provide, withhold, or withdraw consent on my/our behalf, to apply for public benefits to defray the cost of health care, and to authorize the admission or transfer of a minor to or from a health care facility.

I/We will notify and send a copy of this document to the following person(s) other than my/our surrogate, so that they may know the identity of my/our surrogate:

Name: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

#### WITNESSES:

1. \_\_\_\_\_

Date: \_\_\_\_\_

2. \_\_\_\_\_

Date: \_\_\_\_\_

#### Florida Department of Health

##### in Pinellas County

205 Dr. Martin Luther King Jr. St. N. • St. Petersburg, FL 33701-3109

PHONE: (727) 824-6900 • FAX (727) 820-4285

**FloridaHealth.gov**



**Accredited Health Department**  
Public Health Accreditation Board